(21)

No. 89-1869

In The

Supreme Court of the United States

October Term, 1989

FMC CORPORATION

Petitioner,

vs.

CYNTHIA ANN HOLLIDAY

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

BRIEF FOR RESPONDENT

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COUNTERSTATEMENT OF THE CASE

Cynthia Ann Holliday's father was an employee of FMC. Owing to her father's enrollment in FMC's Salaried Health Plan, Ms. Holliday enjoyed coverage for medical expenses pursuant to the terms of the Plan. (J.A. 4-5). Ms. Holliday, then age 15, was injured catastrophically in an automobile collision in White Township, Pennsylvania, on January 16, 1987. Ms. Holliday suffered, *inter alia*, a depressed skull fracture causing severe brain swelling and permanent brain damage affecting her motor and cognitive functions. (J.A. 84). Medical care rendered for these injuries, as of January 18, 1988, cost a total of $178,626.11. (J.A. 113-119). The extent and permanency of her injuries, coupled with her youth, assured that the cost of future care will be substantial.

The Plan provides for coordination of benefits between first-party automobile coverage and the Plan as follows:

> If you or a covered member of your family are eligible to receive benefits under another group medical plan, Health Maintenance Organization (HMO), government plan, or by "no-fault" automobile insurance which provides medical coverage, you may be eligible for benefits from those Plans and your FMC Plan. In the case of coverage by "no-fault" automobile insurance, FMC will pay covered expenses not paid for by no-fault insurance. (J.A. 62-63).
>
> *No-Fault*
> In some states with no-fault motor vehicle coverage, the carrier is the primary insurer in these jurisdictions. All medical expenses related to an accident must be submitted to the carrier and not the FMC Health Care Plan. Eligible expenses not paid for by no-fault insurance *will* be paid by the FMC Plan. (J.A. 68).

(App. 62A)

Under the coordination of benefits and "no-fault" provision of the Plan, the first $10,000.00 in medical bills

were paid by the State Farm Mutual Automobile Insurance Company under a motor vehicle insurance policy owned by Mr. Holiday on the date of the accident. (J.A. 134). The Plan availed itself of the coordination of benefits and no-fault clauses, commencing payment of medical bills only after State Farm's coverage was exhausted. Although the Complaint filed by Petitioner in the District Court alleged that the Plan had expended "approximately $105,000.00 in benefits" for Ms. Holliday (J.A. 5), its Affidavit in Support of Summary Judgment conceded the true amount of "approximately $67,768.00". (J.A. 106). Although Ms. Holliday's medical bills were well in excess of the $100,000.00 threshold required for eligibility under the Pennsylvania Catastrophic Loss Trust Fund, Act of February 12, 1984, P.L. 26, 11-12, 75 Pa.C.S.A. Sections 1761-1769, (App. 223A-2224A), and the Plan provides a one million dollar lifetime maximum per person (J.A. 55), the Plan paid no expenses which qualified for Catastrophic Loss Trust Fund coverage.

The Plan does contain a clause which reserves to itself full subrogation rights. (J.A. 68-69.) The subrogation clause is mandatory, and written "consent" to its mandate is a condition precedent to receipt of benefits. *Ibid.* The claim and subrogation provisions were administered on behalf of FMC by the Equitable Life Assurance Society of the United States, or by one of its affiliate agencies. (J.A. 79, 120.) Mr. Holliday then commenced the civil action as described in Petitioner's brief. Unfortunately, several other individuals suffered injuries of various degrees of severity. Ms. Holliday was thus forced to share $100,000.00 (the only liability insurance proceeds available) with these other claimants. (J.A. 123-125.) On May 2, 1989, an Order was entered approving a settlement by and between Ms. Holliday, three other individuals who made claim against the liability insurance proceeds in response to the interpleader, and the tortfeasor, the effect of which is to limit Cynthia Ann Holliday's recovery from the tortfeasor to $49,875.50, plus accrued interest. (Brief for Petitioner, p. 6, n. 3.)

FMC notified Mr. Holliday of its intent to exercise subrogation rights with respect to these funds. The Statement of Facts set forth on pages seven and eight of the Petitioner's Brief fairly summarizes the circumstances which followed such notice.

SUMMARY OF ARGUMENT

The clear language of ERISA contains no mandate that state anti-subrogation laws be preempted as applied to self-funded employee welfare benefit plans. Other sections of ERISA demonstrate that Congress' purpose in enacting that statute was to assure integrity and national uniformity in the day-to-day funding and administration of plans, not to allow plans to operate without incidental constraints imposed by state law.

Nor does ERISA's legislative history reveal that Congress intended to preempt laws such as Pennsylvania's anti-subrogation statute when it enacted §514. The legislative history is consistent with the previously described objects and policies of Congress, none of which suggests that Congress intended to obliterate all state laws as applied to self-funded employee welfare benefit plans.

The decisions of this Court interpreting ERISA §514 have consistently sought the aims to be achieved by Congress in enacting ERISA, and have analyzed not only the language of §514 itself, but also the language of the entire statute. This Court has never held that all self-funded employee welfare benefit plans are exempt from all state insurance laws by virtue of the "deemer" clause. The lower courts' ruling is consistent with the prior holdings of this Court addressing the scope of §514.

Reversal of the lower court will not further any of the substantive policy underlying ERISA, as obliteration of state anti-subrogation insurance laws as applied to self-funded plan will not relieve plan fiduciaries of substantial, day-to-day administrative burdens or reduce the risk of enforcement of state remedies against the plans. Such a

result would, however, seriously damage the states' ability to manage insurance in tort matters within their own borders, risking chaos in the automobile tort system and depriving plan participants of just recoveries.

ARGUMENT

I. THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 DOES NOT PREEMPT THE PENNSYLVANIA MOTOR VEHICLE FINANCIAL RESPONSIBILITY LAW OF 1984.

A. The statutory language documents Congress' intent to forego preemption of all state insurance laws.

Petitioner and the Solicitor General espouse the position that ERISA §514 justifies a blanket eradication of all state laws affecting self-funded employee welfare benefit plans. Such a position cannot withstand a careful analysis of the language or history of the statute.

The essence of federal preemption analysis is the discovery of Congressional intent to preempt. *Metropolitan Life Insurance Company v. Commonwealth of Massachusetts, et al.*, 471 U.S. 724, 738 (1985), (quoting *Mallone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)). This Court has always presumed that Congress does not intend to preempt areas of traditional state regulation. *Metropolitan Life*, 471 U.S. 724, 749 citing *Jones v. Rath Packing Company*, 430 U.S. 519, 525 (1977).

The Court is now well familiar with the preemption clause of ERISA:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.
>
> 29 U.S.C. §1144(a)

> (A) Except as provided in subparagraph (b), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities.
>
> (B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any state purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.
>
> 29 U.S.C. §1144(b)(1)-(2).

This Court employs a tripartite test which parallels the three provisions of §514. First, it is determined whether the state law "relates to" an employee benefit pl..n. If not, it is not preempted. If so, it must be determined whether the state law regulates insurance. Finally, the state law must survive the so-called "deemer" clause of §514(b)(2). *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41, 46 (1987).

The Pennsylvania Motor Vehicle Financial Responsibility Law, Act of February 12, 1984, P.L. 26, #11, §3, as amended by Act of February 12, 1984, P.L. 53, #12, §3, 75 Pa.C.S.A. §1701, *et seq.*, was the Pennsylvania Legislature's second effort to streamline the full tort system utilized by Pennsylvania in motor vehicle accident cases since the discovery of internal combustion.[1] The law

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[1] The Pennsylvania No-Fault Motor Vehicle Insurance Act, the Act of July 19, 1974, P.L. 489, #176, 40 Pa.C.S.A. §109.1 *et seq.*, was repealed by the Motor Vehicle Financial Responsibility Law. While the No-Fault law was the first attempt by

(Continued on following page)

established minimum mandatory benefits for auto policies[2], coordinated benefits among various competing sources of recovery[3], provided for a limited abolition of tort rights with respect to certain types of damages[4], compelled the sale of underinsured and uninsured motorist insurance[5], and provided for a state fund to cover the medical expenses of the most critically injured of motor vehicle victims[6],[7].

Congress has on several occasions acknowledged the states' fundamental right and interest in governing such insurance matters within their own borders. Most pertinent, of course, is the language of §514(b)(1) in which Congress so definitely exempted state insurance laws

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the Pennsylvania Legislature to modify the tort recovery system, it had regulated casualty insurance for many years prior to 1974. See, e.g., Act of May 17, 1921, P.L. 682, Article XI, 40 P.S. §341, *et seq.*

[2] 75 Pa.C.S.A. §1711-1712.

[3] 75 Pa.C.S.A. §1719.

[4] 75 Pa.C.S.A. §1722.

[5] 75 Pa.C.S.A. §1731.

[6] 75 Pa.C.S.A. §1761 et seq.

[7] The Motor Vehicle Financial Responsibility Law itself has been radically amended to address difficulties perceived by both plaintiffs and insurers. Act 6 of 1990, H.B. 121, approved February 7, 1990. This enactment has created a firestorm of controversy, pleasing almost no one and resulting in heated litigation between the Pennsylvania Insurance Department, motor vehicle insurers, and various health care providers, in both state and federal court, alleging the unconstitutionality of various sections of the law and challenging the right of casualty insurers to stop writing policies in Pennsylvania.

from §514(a) preemption that it utilized the word "any" on three occasions in the same sentence.[8]

An earlier, profound recognition of state primacy in the field of insurance is the McCarran-Ferguson Act, 59 Stat. 33, as amended, 15 U.S.C. §1011, *et seq.* Congress therein specifically provided that no federal law should be read to preempt any state law "regulating the business of insurance".[9] This Court has recognized Congress' intentions in this regard, particularly in the field of ERISA preemption. See *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. at 736-737.

Against this backdrop of Congressional policy in favor of preservation of state insurance laws, we now turn to the analysis of §514 as it applies to the anti-subrogation provision of Pennsylvania's Motor Vehicle Financial Responsibility Law.

Petitioner contends, and the Court below determined, that §1720 "relates to" employee benefit plans. Brief of Petitioner, page 11; *FMC Corp. v. Holliday*, 885

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[8] Although certain legislators characterize the exceptions to ERISA preemption as "narrow", the breadth of the language employed in §514(b)(1) leaves little room for doubt that the savings effect is all-encompassing. See also *Metropolitan Life*, 471 U.S. at 741 ("The presumption is against preemption, and we are not inclined to read limitations into federal statutes in order to enlarge their preemptive scope.")

[9] The legislative history of this Act documents the depth and breadth of the state interest in regulation of insurance matters. See Senate Report No. 20, 79th Cong., 1st Session, P. 1 "From its beginning the business if insurance has been regarded as a local matter, to be subject to and regulated by the laws of the several states. This view has been fostered and augmented by decisions of the United States Supreme Court for a period of more than 75 years, leading to the generally accepted doctrine that the business of insurance was not subject to federal law."

F.2d at 84-85.[10] The "relate to" issue has been fully addressed by the Brief filed by the National Conference of State Legislatures et al., as Amicus Curiae in support of Respondent. Id., page 5, N. 2. Respondent urges the Court to consider and adopt the "relate to" analysis as supplied by the National Conference.

All parties are in agreement with the lower courts' determination that the Pennsylvania Motor Vehicle Financial Responsibility Law generally, and its anti-subrogation clause in particular, "regulates insurance" as this Court has defined that term. *Metropolitan Life*, 471 U.S. at 741-744.

Should the Court conclude that MVFR §1720 "relates to" the FMC Plan and given the unanimity of opinion that §1720 is an insurance statute, we now reach the most perplexing aspect of §514, the meaning of the "deemer clause. The Petitioner and the Solicitor General urge the adoption of a so-called "bright line" test for interpretation of the "deemer" clause. This interpretation would result in the total freedom from state insurance regulation of any self-funded employee welfare benefit plan. Such an interpretation is supported by neither the wording of the statute nor its legislative history.

Although Petitioner refers to the so-called "plain language" of the "deemer" clause, Brief for Petitioner at 14,

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[10] Although not briefed extensively in the lower court by the Respondent, the issue is properly before this Court. The tripartite test renders the "relate to" question part of the "Question Presented" as defined on page i of the Petitioner's Brief. Further, it was submitted to the lower court by the brief filed by the Pennsylvania Trial Lawyers Association as Amicus Curiae on behalf of Respondent, and Respondent urged the lower court to consider this issue. Brief for Appellee, p. 17, n. 2. This Court has always considered questions passed on by the courts below no matter how extensively argued by the parties. See, e.g. *Sabbath v. United States*, 391 U.S. 585 (1968); *Jenkins v. Georgia*, 418 U.S. 153 (1974). And, this Court may base its opinion upon any ground supported by the record. *Chevron, USA, Inc. v. Natural Resources Defense*, 467 U.S. 837, 842, N. 7 (1984).

this Court has previously (and politely) recognized that the preemption provisions of ERISA "perhaps are not a model of legislative drafting". *Metropolitan Life*, 471 U.S. at 739. Several common sense observations as to what the "deemer" clause does *not* say are therefore an appropriate launching point for our analysis.

First, the "deemer" clause does *not* say, in so many words, that *no* state insurance law may in any way affect or limit the conduct of a self-funded plan or its fiduciaries. Had Congress intended to adopt this sweeping view, it could have simply drafted §514(b)(2) to read, "No state law regulating insurance shall be saved from preemption insofar as such law has any effect upon a self-funded employee welfare benefit plan." As this Court will assume that "the ordinary meaning of (Congress') language accurately expresses the legislative purpose", *Metropolitan Life*, 471 U.S. at 740 (quoting *Park 'N Fly, Inc. v. Dollar Park 'N Fly, Inc.*, 469 U.S. 189, 194 (1985)), so too should the absence of certain language indicate the absence of a clear legislative purpose which would have been expressed by such language.

Nor does the "deemer" clause in any way express Congress' intent with respect to state subrogation rules. Indeed, one cannot tell from the face of the statute whether Congress gave any thought to such laws in enacting ERISA. The law of subrogation is one which has traditionally been developed through state courts and legislatures. Since Congress must be presumed to have intended not to preempt traditional areas of state concern, *Metropolitan Life*, 471 U.S. at 740, the Court must presume that Congress did not formulate a specific intent to remove statutes such as §1720 from the effect of the "deemer" clause.

Petitioner and the Solicitor General narrow their arguments to focus upon the "deemer" clause itself. While the clause is the obvious starting point for review, this Court's customary approach to statutory interpretation must be minded:

> On numerous occasions we have noted that "'"'[i]n expounding a statute, we must not be guided by a single senterce or member of a sentence, but look to the provisions of the whole law, and to its object and policy.'"'" *Kelly v. Robinson*, 479 U.S. 36, 43 (1986), quoting *Offshore Logistics, Inc. v. Tallentire*, 477 U.S. 207, 221 (1986) (quoting *Mastro Plastic Corp. v. NLRB*, 350 U.S. 270, 285 (1956) (in turn quoting *United States v. Heirs of Boisdore*, 8 How. 113, 122, 12 L.Ed. 1009 (1849))). *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41, at 51 (1987).

Thus, in *Pilot Life*, this Court eschewed a "knee-jerk" preemption argument, and examined in great detail the civil enforcement provisions of ERISA before concluding that preemption of state tort and contract remedies against plan fiduciary was intended by Congress. See 481 U.S. at 51-57.

Several provisions of ERISA shed light on Congress' intent with regard to the scope of regulation and preemption. Perhaps the most fundamental of these provisions is that which defines "employee welfare benefit plan":

> The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the exten that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, *through the purchase of insurance or otherwise*, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship

> funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions). 29 U.S.C. §1002(1) (Emphasis added.)

Congress' definition of "employee welfare benefit plan" without regard to its insured status is a clear signal that the "deemer" clause was *not* intended to form a blanket preemption of all state insurance laws as applied to self-funded employee welfare benefit plans. Congress would hardly have defined such plans with a specific prohibition against differentiation between insured and self-insured plans, while later proceeding to make such a differentiation through the use of the obtuse language of the "deemer" clause.

Petitioner and the Solicitor General also turned their backs on the "object and policy" aspects of the statutory interpretation. ERISA's initial clause sets forth at length the objects and policies which Congress attempted to address and implement by enacting this statute.[11]

There is no mention whatsoever in this clause of the need to provide special protection to self-funded employee welfare benefit plans from a form of state regulation which Congress considered so crucial as to be exempted specifically from preemption. Congress was clearly concerned with the financial integrity of employee benefit plans so that participants would be protected from plans which contained inadequate funding, vesting and termination insurance provisions. The declared policy of Congress was to provide for adequate disclosure, fiduciary standards, federal court remedies, minimum funding standards, and plan termination insurance. 29 U.S.C. §1001(b)-(c). Nowhere in its declaration of policy does Congress indicate that financial soundness of plans is to be achieved through blanket preemption of traditional state regulations, or by the grant to plan fiduciaries

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[11] See 29 U.S.C. §1001.

of such revenue enhancement means as might suit their fancies. §1001 teaches that Congress sought to guarantee *capable*, not *unfettered*, plan management.

Moreover, the legistative history lends little or no support to the position taken by the Petitioner and the Solicitor General. There is nothing in official, contemporary legislative history which directly or indirectly notes that the "deemer" clause was intended to exempt all self-funded plans from the effects of all state insurance laws. Certainly, given the drastic effect which such Congressional action would have upon state regulation of insurance, such a startling departure from long-settled policy would have been the subject of express commentary, if not heated debate, if it had been intended by Congress. In view of the complete absence of any legislative history regarding the meaning of the "deemer" clause and the rationale behind the use of the word "deemed", Petitioner and the Solicitor General attempt to infuse an artificial meaning by reference to broad comments attributable to individual legislators in contexts not focused upon the "deemer" clause. See e.g. Brief for Petitioner at 27, Note 19, Page 30, Note 23: Brief of the Solicitor General, Page 14, Note 9. This Court has previously recognized, however, that such comments are of little use in ferretting out Congressional intent. *Metropolitan Life*, 471 U.S. at 746, N. 24.[12]

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[12] Petitioner and the Solicitor General also refer to the ERISA Oversight Report of the Pension Task Force of the Subcommittee on Labor Standards, House Committee on Education and Labor (1977) as additional evidence of Congress' belief that the "deemer" clause would exempt self-funded plans from all forms of state insurance regulation. This report was, of course, issued several years after ERISA's enactment; its opinions are virtually meaningless in the debate over earlier Congressional intent. See e.g. *Mackey v. Lanier Collection Agency and Service*, 486 U.S. 825, 839-840 (1988). The report is also out of sync with the entire structure of the preemption clauses of

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Since the "deemer" clause cannot be afforded the broadstroke meaning urged by Petitioner and the Solicitor General, we now address what the "deemer" clause *does* mean. Several alternative explanations for the meaning of the clause do exist, and comport more readily with ERISA's regulatory scheme than those advanced by Petitioner and the Solicitor General.

One alternative is to view the "deemer" clause as having been intended to exempt self-funded plans from the "business" end of insurance obligations, such as capitalization and reserves. The Amicus Brief filed by the National Conference of State Legislatures et al., thoroughly discusses this approach to the "deemer" clause. Id. at 9-21. This discussion will not be repeated verbatim here, but is incorporated by reference into this Brief.

A closely related explanation of the "deemer" clause is that supplied by the Court below and by the Sixth Circuit Court of Appeals in *Northern Group Services v. Auto Owners' Insurance Company*, op. cit. The *Northern Group Services* analysis is particularly incisive, in that it carefully reviews the legislative history (such as it is) previously discussed in the briefs of the Petitioner, the Solicitor General and the National Conference, concluding:

> Certain aspects of the legislative history imply that a main concern of Congress in adopting the final broad version of §514 that emerged from the Conference Committee was to avoid intentional – and perhaps pretextual – attempts by states to restrict the discretion of ERISA plans to engage in practices that would otherwise be permitted by federal law. See *American Progressive*

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ERISA. See *Northern Group Services v. Auto Owners' Insurance Company*, 833 F.2d 85, 89 (6th Cir. 1987), Id. at 92, citing *Consumer Product Safety Commission v. GTE Sylvania*, 447 U.S. 102, 117-118, and N. 13, (1980).

Life and Health Insurance Company v. Corkran, 715 F.2d 748, 787 (2d Cir. 1983). 833 F.2d at 93. See also Id., N. 3.

This reading of the "deemer" clause does not require a finding that a state legislature has acted surreptitiously or maliciously to usury federal power. Rather, it is broad enough to encompass intentional efforts by state legislators to encroach upon federal regulation of pension plans. The scope of preemption would then be defined by the "object and policy" analysis utilized by this Court in preemption cases. See, e.g., *Pilot Life*, op. cit.[13] Although condemned by Petitioner and the Solicitor General, the "core concerns" language utilized by the court below says no more than that §514 preempts only those state laws which conflict with ERISA's objectives and

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[13] Senator Jacob Javits, who is quoted by both the Petitioner and the Solicitor General, shed some light on the scope of preemption with the following comments:

> "In view of federal preemption, state laws compelling disclosure from private welfare or pension plans, imposing fiduciary requirements on such plans, imposing criminal penalties on failure to contribute to plans – unless a criminal statute of general application – establishing state termination insurance programs, etc., will be superceded." 120 Congressional Record 29,942, reprinted in 3 Legislative History of the Employee Retirement Income Security Act of 1974, at 4771. While the use of "etc." indicates that Senator Javits did not intend this list to be exhaustive, it further suggests that he intended the list to be representative of the types of state laws to be preempted. Nothing here suggests that Senator Javits contemplated the scope of preemption suggested by Petitioner and the Solicitor General; in fact, the Senator's comments dovetail with the concerns expressed in §1001.

policies.[14] This is precisely how this Court expects the Circuit Courts of Appeals to conduct preemption analysis.

B. The decision of the court below is consistent with this Court's interpretation of §514.

Notwithstanding the arguments posited by the Petitioner and the Solicitor General, Respondent submits that the conduct of the Court below is entirely consistent with this Court's earlier treatment of the preemption clause.

For example, in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), this Court was asked to decide whether §514 preempted a New Jersey statute forbidding ERISA-based pension plans from offsetting benefits by any amounts received by participants from workers' compensation.[15] And in *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983), this Court invalidated the New York Human Rights Law and Disability Benefits Law, insofar as they required plans to pay benefits to employees on pregnancy leave. But neither *Alessi* nor *Shaw* addressed the interface of the insurance savings and "deemer" clauses.[16]

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[14] The Sixth Circuit couched its holding in *Northern Group Services* in terms of the federal interest in national uniformity and the state regulatory program generally applicable to both insured and self-insured ERISA plans. 833 F.2d at 95. This approach is consistent with the "object and policy" analysis employed by this Court. The difference is, again, pure semantics.

[15] In so doing, this Court touched upon an ERISA policy overlooked by the Petitioner and the Solicitor General, i.e., that benefitting employees was a "primary goal" of ERISA, while containing pension costs was a "subsidiary" goal. 451 U.S. at 516. The Court recognized *en passant* the explicit nature of the insurance savings clause. 451 U.S. at 523, N. 19.

[16] *Shaw* was a golden opportunity for adoption of a blanket test that any law which affected a plan was preempted, but the Court did not do so because New York's action "plainly (did) not present a borderline question . . . ". 463 U.S. 100, N. 21.

Moreover, the *Shaw* Court was not required to confront the question of whether a state law which was within a so-called "traditional area of state concern", in light of the history of shared authority between federal and state governments in the area of employment discrimination which does not parallel that of insurance regulation.[17]

Perhaps no decision of this Court is more important to the current controversy than *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724 (1985). This case arose from the efforts of several insurance companies to avoid Massachusetts' mandated benefits law as applied to health insurance policies sold to employee welfare benefit plans. In rejecting the insurer's claims, this Court had an opportunity to evaluate and review the effects of the insurance savings clause and the "deemer" clause upon insurance companies.[18]

In reaching its conclusion, the *Metropolitan Life* Court acknowledged its presumption "that Congress did not intend to preempt areas of traditional state regulation",

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[17] Compare Title 7, Civil Rights Act of 1964, as amended, 42 U.S.C. §2000(e) et seq. with the Pennsylvania Human Relations Act, Act of October 27, 1955, P.L. 744, §1, as amended, 43 P.S. §951 et seq.

[18] Petitioner and the Solicitor General make much of Massachusetts' failure to attempt to enforce its mandated benefit law directly against an ERISA plan, and Massachusetts' concession "that such an application of (the mandated benefit law) would be preempted by ERISA's preemption clause," §514(a), 29 U.S.C. §1144(a). *Metropolitan Life*, 471 U.S. at 735, N. 14. Of course, Massachusetts' position does not bind Respondent in this case, and effectively removed any precedential value which *Metropolitan Life* might have had here. And, as will be discussed later in this Brief, a clear distinction may be made between a state's effort to enforce its mandated benefit law against a self-funded plan and a participant's reliance upon the state law of insurance remedies to prevent a self-funded plan from enforcing a unilaterally-imposed contractual term.

471 U.S. at 740, and indicated that "the presumption is against preemption, and we are not inclined to read limitations into federal statutes in order to enlarge their preemptive scope." 471 U.S. at 741. The Court proceeded to review the preemption clause's legislative history, noting that:

> "(t)he preemption clause apparently was broadened out of the fear that 'state professional associations' would otherwise hinder the development of such employee benefit programs as 'prepaid legal service programs.' " See 120 Cong. Rec. 29197 (1974) (Remarks of Representative Dent); id. at 29933 (Remarks of Sen. Williams); id. at 29949 (Remarks of Sen. Javits). There is no suggestion that the preemption provision was broadened out of any concern about state regulation of insurance contracts, beyond a general concern about "potentially conflicting state laws." See id., at 29942 (Remarks of Sen. Javits). 471 U.S. at 745, N. 23. By contrast, "(t)here is no discussion in that history of the relationship between the general preemption clause and the saving clause, and indeed very little discussion of the saving clause at all." Id.; see also ibid, N. 22.

The Court found that *Shaw v. Delta Airlines, Inc.*, was "of little help" in interpreting the saving clause because "the saving clause is broad on its face and specific in its reference". 471 U.S. at 746, N. 24. The Court rejected the carrier's attempt to narrow the scope of the saving clause through citation of various comments made by Representative Dent and Senators Williams and Javits, most of which have been cited by Petitioner and the Solicitor General in support of their broad reading of the "deemer" clause. Ibid. To suggest that such comments strongly support an expansive reading of the "deemer" clause when this Court has already determined that they are too "frail" to support a narrow reading of the insurance saving clause is to defy logic.

Respondent certainly recognizes the Court's comments regarding the distinction between insured and uninsured plans. 471 U.S. at 474. As the Solicitor General concedes, this Court's observation was not central to its holding. Brief for the Solicitor General, p. 17.[19] This Court has never considered its dicta to be any part of its holding. *McDaniel v. Sanchez*, 452 U.S. 130 (1981).

Perhaps most importantly, *Metropolitan Life* addressed the vitality of a state law which by its very nature was more likely to have widespread and profound impact upon self-funded employee welfare benefit plan than the Pennsylvania anti-subrogation statute. The Massachusetts statute directed insurers to offer minimum level mental health coverage in any policy sold within that Commonwealth. *Metropolitan Life*, 471 U.S. at 731. The law was enforced against Metropolitan and the Travelers Insurance Company through a state court proceeding which sought a permanent injunction against the continued sale of policies which did not conform to the state law. Id., at 734. Enforcement of the Massachusetts law against the fiduciary of a self-funded plan places the fiduciary at risk of liability for any remedies granted the state under the mandatory benefits law, including civil fines and possible imprisonment in the event a state court determines that the fiduciary has violated an injunctive order. One may conceive that Congress intended to prevent plan fiduciaries from this type of risk.

The Pennsylvania anti-subrogation law is entirely different in character. It provides for no affirmative remedy against any plan fiduciary. It imposes no obligation upon any plan, and does not require the plan to take any action whatsoever. It imposes upon the plan fiduciary no

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[19] In view of Massachusetts failure to enforce its mandated benefits laws against self-funded plans, Petitioner's characterization of this language as part of the Court's holding (Brief of Petitioner, at 15-16.) is undoubtedly wrong.

ongoing obligation to pay benefits, process particular types of claims, or maintain additional records. It simply provides that the plan has no greater rights than an insurance company to attempt to enforce, by contractual clause or otherwise, a traditional state remedy which had been abolished as part of a comprehensive automobile insurance regulatory scheme.

Several later decisions of this Court support the distinction between mandated benefits and anti-subrogation laws. In *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41 (1987) this Court found that a state cause of action for contractual bad faith was not saved by §514(b)(1), and consequently did not address the scope of the "deemer" clause.[20] Noting that "the purpose of Congress is the ultimate touchstone," 481 U.S. 41, 45, the Court looked beyond the *Metropolitan Life* decision to examine "the role of the saving clause in ERISA as a whole." Id. at 51. The opinion cites to the civil enforcement provisions of ERISA, finding that "the policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." Id. at 54. *Pilot Life* cannot, therefore, be cited for the proposition that Congress intended to preempt anti-subrogation laws when it enacted §514, as the state law challenged there created the affirmative burden of administration and risk of recovery against plans which Congress intended to forbid.

Two later decisions of this Court reject the sweeping proposition posed by Petitioner that self-funded plans are free from the effects of all state laws. In *Fort Halifax Packing Company, Inc. v. Coyne*, 482 U.S. 1 (1987) the Court determined that a Maine statute requiring a one-time severance payment to employees upon plant closure was

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[20] See 481 U.S. at 51.

not preempted by ERISA. In so holding, the Court announced:

> " . . . in effect, Appellant argues that ERISA forecloses all state legislation regarding employee benefits. This contention fails, however, in light of the plain language of ERISA's preemption provision, the underlying purpose of that provision, and the overall objectives of ERISA itself." 482 U.S. at 7.

The Court found the Maine statute to survive §514 because it neither mandated the creation of a plan nor imposed ongoing administrative demands on an existing plan. Id. at 12-14.

Of equal importance was the Court's concern with the statute's failure "to implicate the regulatory concerns of ERISA itself." Id. at 15. The Court noted that "the focus of the statute thus is on the administrative integrity of benefit plans . . . " and found in both 29 U.S.C. §1001 and portions of legislative history that Congressional policy with respect to the fiscal integrity of plans was aimed, not at allowing plans to collect monies in any manner deemed appropriate by their fiduciaries, but rather to protect the participants from mis-mal- or non-feasance by fiduciaries. Id. at 15.

The Court had the opportunity to focus its attentions directly upon a traditional state law function in *Mackey v. Lanier Collections Agency and Services, Inc.*, 486 U.S. 825 (1988). At issue were Georgia's regulations concerning collection of money judgments. One of these exempted ERISA plans from garnishment proceedings. This Court struck down the protective act, holding that the statute (which expressly referred to ERISA plans) obviously "related to" such a plan and did not come within any of the exceptions contained in §514(b). But this Court went on to reject a contention that Georgia's general garnishment statute was preempted when applied to ERISA plans. Noting that "it is the intent of the Congress that enacted (the Section) . . . that controls", citing *Teamsters v. United States*, 431 U.S. 324, 354, N. 39 (1977), the Court

examined the "sue or be sued" provisions of ERISA and concluded that Congress intended ERISA plans to be subject to state garnishment laws. In so doing, the Court acknowledged that "lawsuits against ERISA plans for run-of-the-mill state law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan – are relatively commonplace", 486 U.S. at 833, and cited the concession of the Petitioners and the Solicitor General that such suits "although obviously affecting and involving ERISA plans and their trustees, are not preempted by ERISA §514(a)". The Court refused to find preemption, despite the Petitioner's apparently undisputed contention that increased administrative burden and cost would result from plan susceptibility to state law garnishment proceedings. 486 U.S. at 831. *Mackey* thus demonstrates that preemption under §514(a) requires more than an assertion or finding of administrative inconvenience or cost to a plan.

The thrust of the foregoing analysis is that this Court has routinely and uniformly examined the Congressional intent and policy behind the preemption provisions of ERISA. At no time has this Court every adopted a so-called "bright line" test for any portion of §514. No holding of this Court has ever determined that it was Congressional policy to eradicate state automobile insurance or subrogation laws as applied to self-funded employee welfare benefit plans. The lower court's reference to "core concerns" of ERISA, while perhaps not artfully framed, is nothing more than an effort to ferret out Congressional intent regarding the scope of §514. The lower court followed the procedures established by this court for statutory interpretation, and rendered a decision consistent with the prior holdings of this Court.[21]

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[21] Petitioner contends that the lower court's opinion in this case "is inconsistent with the weight of appellate authority". Brief of Petitioner, pages 16-17. As previously noted by Respondent, however, most of the cases cited by Petitioner

(Continued on following page)

II. REVERSAL OF THE LOWER COURT'S DECISION WILL NOT FURTHER THE AIMS OF ERISA.

As there is no statutory language or legislative history addressing the effect of the "deemer" clause upon either self-funded employee welfare benefit plans or state anti-subrogation statutes, there is no express Congressional purpose or policy upon which reversal of the lower court's judgment may be based. Petitioner and the Solicitor General thus point to various broad ERISA policies which they claim to be violated by the Pennsylvania statute. A close examination of Petitioner's position reveals, however, that these policies do not act to support preemption here.

Petitioner's first concern is that the lower court's ruling violates the Congressional policy in favor of national uniformity of plan administration, citing *inter alia* its own experience in the subrogation field. Undoubtedly, Congress intended regulation of essential day-to-day plan business of employee welfare benefit plans to be left exclusively to the federal government, so as to guarantee that the benefits of uniformity in ongoing administrative practices would accrue to plans. However, neither Congress nor this Court has ever declared that ERISA was intended to establish self-funded plans as a law unto themselves. As this Court recognized in *Metropolitan Life*:

> "We are also aware that Appellant's construction of the statute would eliminate some of the disuniformities currently facing national plans that enter into local markets to purchase insurance. Such disuniformities, however, are the inevitable result of the Congressional decision to 'save' local insurance regulation. Arguments

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(Continued from previous page)

have little or nothing to do with the question of state anti-subrogation laws as applied to self-funded benefit plans. See Respondent's Brief in Opposition to Petition for Writ of Certiorari, pages 8-10.

> as to the wisdom of these policy choices must be directed at Congress." 471 U.S. at 747,

Nothing in the statute or legislative history reveals why self-funded plans should be spared all disuniformity while insured plans are not, particularly since Congress defined "employee welfare benefit plan" to include all such plans, whether funded by insurance or not. 29 U.S.C. §1002(1)[22] The issue to be addressed by this Court is not interstate disuniformity of plan administration, *per se*, but rather the types of interstate disuniformity of plan administration which Congress sought to prevent.

Moreover, subrogation is not the sort of matter with which Congress appeared to be concerned in enacting Section 514. Congressional concern appeared to center around the avoidance of duplicative record keeping and day-to-day, alternative paper requirements which might be imposed by conflicting state and local regulations. See *Fort Halifax Packing Co.*, 482 U.S. at 12-15. An anti-subrogation law imposes no administrative burden upon a plan fiduciary, and does not raise the spectre of state audits of plan documents or state court actions challenging fiduciary conduct.

Petitioner's concerns regarding disuniformity are further diluted when one considers that many self-funded plans are administered by insurance companies which provide administrative services for a fee. See, e.g. Brief of the Travellers Insurance Company as Amicus Curiae in support of Petitioner, pages 1-2. Indeed, at the time Respondent's father applied for benefits, Petitioner utilized the Equitable Life Assurance Society of the United States as its Claim Administrator. Joint Appendix,

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[22] If disuniformity is to be avoided at all costs, the outcome in *Mackey* would have been quite different. Interstate plans are susceptible to suit in certain states on certain causes of action which might not exist in other states. Such plans will also have to be administered with an eye towards each state's procedural requirements (e.g. garnishment), which differ from state to state.

page 120. Plans such as Petitioner can hardly complain of the difficulties of interstate plan administration where, as noted by the Solicitor General, "the insurance company that sold the policy – which should be accustomed to inconsistent regulation in light of the long tradition of state primacy in the area of insurance regulation – would presumably assist the purchaser in adjusting to the different rules of the various states." Brief of the Solicitor General, pages 27-28, N. 25.

Petitioner's next concern is reduction of litigation through adoption of a bright-line test. This Court has previously recognized that the structure of §514 necessarily invites litigation. See, e.g., *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. at 47. Given the ambiguities of Section 514, it is doubtful that reversal of the lower court here will prevent any substantial amount of future litigation over the meaning of the "deemer" clause in areas other than the narrow one presented in this case, i.e., the application of anti-subrogation insurance laws to self-funded plans. Further, since a federal common law of ERISA rights and obligations is to be expected, see *Pilot Life*, 481 U.S. at 55-56, self-funded plans may be expected to appear in the federal courts repeatedly over the years. The degree to which adoption of Petitioner's position will result in reduced litigation is a matter of pure speculation.[23]

Petitioner next frets over the increased cost to plans by state laws avoiding subrogation rights. The record is, of course, devoid of any evidence as to the degree to which anti-subrogation insurance laws impinge upon the fiscal soundness of self-funded plans, or of the degree to which the benefits to be offered to participants will be trimmed as a direct result of the unavailability of

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[23] Indeed, a sound argument exists to suggest that sustaining Petitioner's position will result in increased litigation. See Brief for the National Conference of State Legislatures et al., as Amicus Curiae in Support of Respondent, pages 26-27.

subrogation.[24] Naturally, Petitioner's cost argument presupposes that Congress intended every state law which could conceivably cost a plan money to be preempted. The *Mackey* Court rejected this notion, and nothing in the

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[24] The Brief of The National Coordinating Committee for Multiemployer Plans as Amicus Curiae in Support of Petitioner, cites the limited experience (and future expectations) of one plan and a 1984 study indicating that one to two percent of all medical claims can be recouped through a "vigorous subrogation program" Id., page 20, note 16. This "study" consists of citation to four cases (including one in which the amount of gross recovery is undisclosed), and the early experience of an unidentified "Fortune 50" corporation in twenty-two cases, at least nineteen of which were *expected* (rather than *actual*) subrogation recoveries. It is the experience of this Fortune 50 company upon which the one to two percent figure is based.

One cannot tell from the original article whether these were gross recoveries or net amounts received by the subrogor after the claims administrators and attorneys had been paid. In any event, while subrogation would concededly result in some financial benefit to self-funded plans, these nuggets are an insufficient basis for adoption of the sweeping policy demanded by Petitioner.

The article cited by Amicus goes on to note that many insurance carriers do not find subrogation worth the trouble. Wille, *Subrogation/Third Party Reimbursement: An Overlooked Way to Reduce Health Benefit Costs*, 1 Health Cost Management No. 9, at 4 (June, 1984). While the author attributes this phenomenon to insurer sloth, an alternative explanation may be a market-tested experience that subrogation is not as cost-effective as Petitioners would have the Court believe.

Finally, Petitioner overlooks the fact that only subrogation in motor vehicle cases has been abolished in Pennsylvania. Petitioner retains its full subrogation rights in other sorts of litigation, such as products liability, medical malpractice, and premises cases. No authority is cited to indicate that anti-subrogation laws are (or will become) prevalent in these areas.

legislative history or the statute itself is cited to support so broad a reading of Congressional intent.[25]

Finally, Petitioner almost incredibly suggests that precluding subrogation by self-funded plans against participant's tort recoveries will thwart congressional intent "without returning any real benefits to plan participants." Brief of Petitioner, page 30. The obvious benefit to the participant is prompt payment of medical benefits coupled with more prompt resolution of his/her tort claim, due to the absence of a complicating factor: a subrogor-plan. Obviously, the presence of a subrogor-plan complicates the tort settlement process, as each dollar not received by the participant must be recouped via a higher settlement demand, in turn creating greater resistance to settlement by the tortfeasor and/or his liability carrier. Greater difficulty in settlement naturally translates into more trials and cases in which defense verdicts remove any monetary recovery from the hands of the participant (and, consequently, the subrogor-plan).

Alternatively, as has occurred with Respondent, a participant's injuries may be so grave and the sources of liability insurance recovery so limited that a subrogation lien will assure that the participant will not receive a fair measure of recovery. Several of the Amicus Briefs decry the "double recovery" which they assume many plan participants to have received. Of course, there is no statistical data to support the notion that double recovery is

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[25] Various of the Amicus Briefs point to the burgeoning cost of health care as a justification for maintenance of subrogation rights in self-funded plans. Obviously, health care cost containment is a national concern, affecting both plans and participants alike. It remains a mystery as to how anti-subrogation laws have caused this phenomenon, or why a holding in favor of Petitioner would stem the tide. Respondent suggests that health care costs are better managed by comprehensive Congressional action, rather than by incremental invasions into traditional areas of state regulation under a federal statute not designed to address the particular problem.

pervasive. In the instant case, for example, Petitioner is a teenage girl who suffered a severe brain injury as a result of her depressed skull fracture. She will net less than $50,000.00 from her tort action against the negligent driver. While it is unclear how much of her medical bills will have to be paid out of her recovery, she has suffered damages for impairment of earning capacity, pain, suffering and inconvenience far in excess of what she will ever recover, even if this Court finds in her favor. (J.A. 84-85).

A related difficulty with Respondent's position arises from the likely damage to the states' motor vehicle claims processes resulting from the adoption of Petitioner's position. This Court has previously expressed its sensitivity to maintenance of the states' tort systems in the face of federal preemption. *San Diego Building Trades Council v. Garman*, 359 U.S. 236, 248 (1959). Pennsylvania has recently abolished the so-called "collateral source" rule with respect to motor vehicle accident claims,[26] thus prohibiting double recoveries for medical expenses. However, this provision is part-and-parcel of a comprehensive automobile insurance program which includes the anti-subrogation statute challenged now. If Petitioner's fears are correct, plan participants who do not have sufficient medical coverage under their automobile insurance policy will look to their self-funded plans for payment of

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[26] "Preclusion of recovering required benefits. In any action for damages against a tortfeasor, or in any uninsured or underinsured motorist proceeding, arising out of the maintenance or use of a motor vehicle, a person who is eligible to recover benefits under the coverages set forth in this subchapter, or Worker's Compensation, or any program, group contract or other arrangement for payment of benefits as defined in Section 1719 (related to coordination of benefits) shall be precluded from recovering the amount of benefits paid or payable under this subchapter or Worker's Compensation or any program, group contract or other arrangement for payment of benefits as defined in Section 1719". 42 Pa.C.S.A. Section 1722, effective July 1, 1990.

medical bills. The amounts paid by the plans will not be recoverable in any tort action, as Section 1722 is a *per se* bar to such recoveries.[27] Plans will, in Petitioner's world, be permitted to subrogate against recoveries or settlements which cannot include dollars attributable to the expenses covered by the plans. Thus, plan participants doubtless will have grossly inadequate (rather than double) recoveries for injuries sustained in motor vehicle accidents. This will be a national phenomenon, given the widespread use of anti-subrogation laws in no-fault states. See *Wille, op. cit.*, pages 3-4.

CONCLUSION

For the foregoing reason, the Respondent prays this Court to affirm the judgment of the Third Circuit Court of Appeals.

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[27] Petitioner has not challenged in this Court the finding that the FMC plan is a "program, group contract or other arrangement for payment of benefits" as defined in the anti-subrogation statute. This portion of Section 1722 is identical to Section 1720 in this vein.